PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS: MEDICINE'S BEST ALLY

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PROFESSIONAL Standards Review Organizations (PSROs) work. They are cost-effective and they are medicine's best ally. The first two points are well documented by a widely publicized study conducted by the federal Office of Planning, Evaluation and Legislation (OPEL). Although this report found that few PSROs had been effective during their start-up years, it did state, however, in reporting on the performance of the Foundation for Medical Care Evaluation of Southeastern Wisconsin, that "Milwaukee's excellent performance relative to its comparison site and to most other PSROs in the country, represents a sign that PSROs can be effective."[1]

The statement that PSROs are medicine's best ally, although more debatable, is equally defensible. Senator Bennett, in justifying the PSRO law, said:

> The challenge we faced, then, was to develop a review system which would properly balance the interests of the physicians, the government, and, of course, the patient. We did not want—and the PSRO legislation was an attempt to avoid—a program under which private insurance clerks and government bureaucrats would review medical care, and then only retrospectively. On the other hand, we could not realistically propose a program under which physicians could do whatever they felt like doing, with no accountability whatsoever to the government or to private payers.[2]

It is hard to argue against his reasoning. It is also interesting to note—a point lost to most observers—that the last four words of his statement were: "or to private payers." It was a clear forecast that the same peer-review system was relevant to private patients.

Peer review is an acceptable and proud part of our professional heritage. In one way or another, as physicians we have been involved in it ever since we entered our postgraduate training, yet few of our patients knew it existed. However, if today we were to ask them what they want from us,

their answer would be, with minimal translation, "Quality care at a fair price." PSRO defines this as professional standards review and cost containment. Industry merely calls it quality control.

But why call PSRO an ally? Most hospital staffs profess that they are good doctors; that they have been conducting peer review for many years; that they have taken disciplinary action against the few backsliders; and, therefore, they do not need PSRO or anybody else looking over their shoulders. Unfortunately, Congress, consumer groups, industrialists, labor leaders, private health insurers, and even many of their own patients—provided they are not sick at the time—fail to share that same conviction. To settle this conflict, PSRO seems to have come, quite inadvertently, to our rescue. It establishes a data base which can prove, once and for all, whether or not there is abuse of expensive hospital facilities by patients who, in the medical judgement of physicians, do not require hospitalization. We can never prove that point by pious statements, but we can with hard performance data.

Stripped of all its bureaucratic jargon, PSRO requires physicians to make only four decisions: 1) who is sick enough to be in a hospital, 2) how long they need to stay, 3) are they receiving care at the right level, and 4) is the care they receive of a professionally acceptable quality? There is nothing in that mandate which violates the standards of medicine or interferes with the prerogatives of the physician. In fact, we would rise up in arms if someone suggested that these decisions were not within our responsibility.

If we are, indeed, doing as well as we claim we are, the data which PSROs can produce will prove it to anyone who claims we are doing otherwise.

If it happens that some physicians are performing less efficiently than we had thought, the rigid confidentiality rules of PSRO provides them with the opportunity to improve their performance under only the watchful eyes of their peers. Obviously, our performance will never be perfect. The advances of medicine will always be utilized at differing speeds by differing individuals. Since there is no sign that new drugs, new devices, new diagnostic and therapeutic procedures, and new medical miracles will cease, PSROs will be as dynamic as medicine itself.

However, once—and it must not be too far into the future—PSRO data match acceptable norms and standards, we can, then, with proof positive, argue that if there are financial problems in the health-care delivery

system, they are not due to improper utilization. It is our job to document that every patient receives only that care which in the opinion of the profession is medically necessary, neither more nor less. If the costs of providing that necessary care are still intolerable, then those responsible for health-care financing must make the political decision of choosing among putting more money into the system, cutting back costs, and rationing benefits. These are not medicine's responsibilities. With the data which PSROs can produce, we can refute with hard facts any maneuver to deprecate our efforts by calling us the fox guarding the hen house. If we can prove that the hen house is secure and is being guarded effectively and economically by those who know it best, any further use of this cliche would be sheer demagoguery.

We should be on guard to see that Congress never takes away from us the power to make the professional decisions required by PSRO. Both we and they must accept the inevitability that utilization rates may temporarily drop, but that as our population ages, as beneficiary groups are added, and as the science of healing follows its exploding course, usage by patients with documentably medically necessary conditions will climb. To press for a reduction of utilization year after year would be to ration health care. That is not America's style, but to see that precious resources are not wasted is in tune with the times.

Any close observer of the health-care scene recognizes that this country has passed through an unfortunate period of abundance and irresponsibility on the part of many of us in the health-care field—stimulated, in great measure, by the outpouring of governmental funds for all facets of health. Unfortunately, we have now entered into a compensatory period of correcting irresponsibility by irrationality. Government, in desperation, is now convinced that medicine can and must be controlled by regulation. Most physicians, on the other hand, believe that medicine does not need control, it needs change. We agree with the Harvard political economist, Richard Zeckhauser, who has expressed "little hope that regulation can dramatically change the health-care system."[3] But, PSRO being one of the few examples of a joint venture between government and medicine, it can bring about at least rational change, within the limited sphere of utilization and quality. It can lead us into a standard of care which we all want and which our patients deserve.

Therefore, let us be selective in our opposition to governmental involvement in the health-care system. Let us support that which is good and

oppose that which is bad. PSRO may be our patients' greatest asset and medicine's best ally.

SUMMARY

PSRO is a successful and cost-effective mechanism for peer review which physicians should support not only for the sake of good medical practice, but because it can be used to their own advantage. Although originally designed to control the practice patterns of physicians, both as to utilization and quality, the law also requires the collection of data that for the first time can prove whether or not physicians are abusing hospital utilization. If there are deficiencies, PSRO provides physicians an opportunity confidentially to improve their performance. Once it is documented that every patient receives only the care that is medically necessary, if the cost of that care is then more than the government budgeted, the problem is political, not medical. While urging compliance with PSRO, there is a warning that physicians must be selective in their support of governmental programs.

REFERENCES

1. PSRO: *An Evaluation of Professional Standards Review Organizations: A Report of the Office of Planning, Evaluation and Legislation*. Health Services Administration, DHEW. No. OPEL 77-12, 1977.
2. Bennett, W. F.: Presentation at the *Annual Meeting of the American Association of Foundations for Medical Care*. Sea Island, Ga., August 28, 1972.
3. Zeckhauser R.: Little hope for change from regulations. *Hospitals 52:* 20-21, 1978.

ERRATUM

In the May issue of the *Bulletin* the last word on the fifth line of page 501 should be membership.